

42 CFR OTHER DIAGNOSTIC AND PREVENTIVE SERVICES
440.130

Diabetes Self Management Training

Diabetes Self Management is an educational process to teach the individual how to successfully manage and control diabetes. The training will increase the individual's understanding of disease progression and teach monitoring skills to prevent complications, disease progression, and disability. As a result of the training the individual will be able to identify potential diabetes-related problems, establish achievable self-care goals, and take responsibility for maintaining a healthy lifestyle that promotes quality mental and physical health. The program Coordinator will be responsible for maintaining ongoing open communication with the patient's physician. The Coordinator will inform the physician of the patient's progress, compliance, or issues of concern identified while the patient's training is in progress. Evaluation of the patient training will occur with each session, at the conclusion of training, and the program Coordinator will complete follow up with the patient several months after the training. Issues or concerns will be communicated directly to the physician.

LIMITATIONS

1. Diabetes self management is limited to a maximum of ten hours of outpatient service. Instructors eligible to provide diabetes self management training will include Utah licensed registered nurses and certified dietitians who are eligible under their scope of practice to provide counseling for patients with diabetes and monitor patient compliance with the plan of care.
2. Diabetes self management is limited only to the program that meets the National Diabetes Advisory Board standards (NDAB) and is recognized by the American Diabetes Association (ADA) or certified by the Utah Department of Health.
3. Diabetes self management is limited to that certified by the physician, under a comprehensive plan as essential to ensure successful diabetes management by the individual patient.
4. Diabetes self management is limited only to the training presented in a certified program that meets all of the NDAB standards and is recognized by the American Diabetes Association (ADA) or certified by the Utah Department of Health.
5. Diabetes self management includes group sessions, but must allow for direct face-to-face interaction between the educator and the patient, to provide opportunity for questions and personal application of learned skills.
6. Diabetes self management must be sufficient in length to meet the goals of the basic comprehensive plan of care. Individual sessions must be sufficient in number and designed to meet the medical and instructional needs of the individual.

T.N. No. 99-008
Supersedes
T.N. No. NEW

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Diabetes Self Management Training (continued)

7. Repeat of any or all of a diabetes self management program is limited to new conditions or alteration of health status that warrants the need for new training.
8. Home Health Agency participation in diabetes self management is limited to providing service to the homebound patient, who is receiving other skilled services in the home based on physician order and plan of care.
9. Diabetes self management service provided by a home health agency must be provided only by a licensed RN or dietitian certified or recognized by an American Diabetes Association (ADA) program or Utah Department of Health.

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42 CFR
440.140

SERVICES FOR INDIVIDUALS AGE 65 OR OLDER
IN INSTITUTIONS FOR MENTAL DISEASE (IMD)

LIMITATIONS

1. Services for individuals age 65 or older in an institution for mental disease are a benefit of the Medicaid program in a hospital licensed as a Specialty Hospital - Psychiatric, under the authority of Utah Administrative Code R432-101. Services must be provided under the direction of a physician.
2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
 - a. that the proposed services are medically appropriate; and
 - b. that the proposed services are more cost effective than alternative services.

TN No. 98-003
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TN No. 93-31

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Intermediate care facility services (other than services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

In accordance with section 1919(f)(7) of the Act, personal hygiene items and services may be charged to the patient's personal needs fund. The following limitations apply.

Limitations

1. The following personal hygiene items and services may, at the request of the patient or the patient's advocate, be charged to the patient's personal needs fund:
 - a. Personal grooming services such as cosmetic hair and nail care;
 - b. Personal laundry services;
 - c. Specific brands of shampoo, deoderant, soap, etc. requested by the patient or patient's advocate and not ordinarily supplied by the nursing home as required in 2(a) and (b) below.
2. In accordance with State Plan amendment 4.19-D, Nursing Home Reimbursement, the following personal hygiene items and services may not be charged to the individual's personal needs fund:
 - a. Items specific to a patient's medical needs, such as protective absorbent pads (such as Chux), prescription shampoo, soap, lotion, etc.
 - b. General supplies needed for personal hygiene such as tooth paste, shampoo, facial tissue, disposable briefs (diapers), etc.

T.N. # 88-22
Supersedes _____
T.N. # _____

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42 CFR
440.160

INPATIENT PSYCHIATRIC FACILITY SERVICES
FOR INDIVIDUALS UNDER 21 YEARS OF AGE

LIMITATIONS

1. Inpatient psychiatric services for individuals under age 21 are a benefit of the Medicaid program only for care and treatment provided under the direction of a physician in a hospital licensed as a Specialty Hospital - Psychiatric, under the authority of Utah Administrative Code R432-101, 1992 as amended.
2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
 - a. that the proposed services are medically appropriate; and
 - b. that the proposed services are more cost effective than alternative services.

TN No. 48-003
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SCOPE OF SERVICES

INTENSIVE SKILLED CARE (NURSING HOMES)

In order to care for the more acutely ill patient being admitted to Skilled Nursing Facilities from hospitals, a new level of care will be adopted.

Patients admitted requiring nursing care, rehabilitation and other services over and/or above usual circumstances will be classified as Intensive Skilled.

The Health Facilities Preadmission Unit will assess patients for this category of service. Classification in this area will be based on nursing home, patient assessment, length of stay and services required to meet individual patient's needs.

Health Care Financing will contract with all nursing homes admitting Intensive Skilled Care patients for specialized services meeting individual patient's needs.

If necessary, patients in this category should have available rehabilitative services to assist in restoring to maximum potential.

RECEIVED
MAR 2 10 56 AM '82
HEALTH FACILITIES
FINANCING
ADMINISTRATION

Remove this? 17.4

*18.6 - Should be 23.f?
Personal Care limited to HHA
Should be HHA service*

*Pg 7 3.1A Nurse will write -
says limitation - what is it*

T.N. # DOH HCF 12-2

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5/7/82

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4/1/82

24 CFR
440.170

PERSONAL CARE SERVICES IN A RECIPIENT'S HOME

LIMITATIONS

1. Personal care services are covered benefits when provided by a home health agency licensed in accordance with Utah Code Annotated, Title 26, Chapter 21. Services are delivered by a personal care aide or a home health aide (performing only personal care level tasks) who has obtained a certificate of completion from the State Office of Education, or a licensed practical nurse, or a licensed registered nurse. Personal care services are prescribed by a physician and are provided under the supervision of a registered nurse. Personal care services are not provided by a member of the recipient's family.
2. Personal care services are covered benefits only for recipients who (a) receive services in their place of residence that is not an institution; (b) do not receive Medicaid home health aide services on the same day they receive personal care services.
3. Personal care services are limited to 60 hours per month.
4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
 - a. that the proposed services are medically appropriate; and
 - b. that the proposed services are more cost effective than alternative services.

TN No. 98-003
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TN No. 89-23

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TB RELATED SERVICES TO TB INFECTED INDIVIDUALS

OBRA 1993
Section 13603

LIMITATIONS

1. Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease that may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patient's history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.
2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
 - a. that the proposed services are medically appropriate; and
 - b. that the proposed services are more cost effective than alternative services.

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EXTENDED SERVICES TO PREGNANT WOMEN

The following major categories of service are available as pregnancy related or post partum services for a 60 day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

1. Inpatient Hospital Services

Limitations identified in ATTACHMENT 3.1-A (Attachment #1)

2. Outpatient Hospital Services

Limitations identified in ATTACHMENT 3.1-A (Attachment #2)

3. Family Planning Services

Limitations identified in ATTACHMENT 3.1-A (Attachment #4.c)

4. Physician Services

Limitations identified in ATTACHMENT 3.1-A (Attachment #5)

5. Home Health Visits

Limitations identified in ATTACHMENT 3.1-A (Attachment #20.b, page 3)

6. Medical Supplies and Equipment

Limitations identified in ATTACHMENT 3.1-A (Attachment #7.c)

7. Prescription Drug Services

Limited to treatment of pregnancy related conditions, complications, and family planning. Limited also to those limitations identified in ATTACHMENT 3.1-A (Attachment #12.a)

8. Certified Registered Nurse Midwife Services

Limited to the maternity cycle, i.e., pregnancy, labor, birth, and the immediate postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60 day period following termination of pregnancy ends.

9. Certified Pediatric and Family Nurse Practitioners

Limitations identified in ATTACHMENT 3.1-A (Attachment #23)

T.N.# 93-015
Supersedes T.N.# NEW Approval Date 5/20/93 Effective Date 4/1/93

EXTENDED SERVICES TO PREGNANT WOMEN

The following services are being expanded beyond limitation for all groups described and the services are provided only for pregnant women.

A. Physician Services

Risk Assessment

Risk assessment is the systematic review of relevant client data to identify potential problems and plan for care. Early identification of high risk pregnancies with appropriate consultation and intervention contribute significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality. The care plan for low risk clients incorporates a primary care service package and additional services specific to the needs of the individual client. High risk care includes referral to or consultation with an appropriate specialist, individualized counseling and services designed to address the particular risk factors involved. Risk assessment will be accomplished using the Utah Perinatal Record System or other formalized risk assessment tool. Consultation standards will be consistent with the Utah Medical Insurance Association guidelines.

Limited to two risk assessments during any 10-month period.

Prenatal Assessment Visit (Initial Visit Only)

The initial prenatal visit for a new patient with a confirmed pregnancy, providing an evaluation of the mental and physical status of the patient, an in-depth family and medical history, physical examination, development of medical data, and initiation of a plan of care.

Limited to one visit in any 10-month period, to be used only when patient is referred immediately to a community practitioner because of identified risks or otherwise lost to follow-up because patient does not return.

Single Prenatal Visit (Visit Other Than Initial Visit)

A single prenatal visit for an established patient who does not return to complete care for unknown reasons. Initial assessment visit was completed, plan of care established, one or two follow-up visits completed but no follow through with additional return visits.

Limited to a maximum of three visits in any 10-month period, to be used outside of global service, only when the patient is lost to follow-up for any reason.

High Risk Pregnancy Care

High risk pregnancy as determined and reported through use of the formalized risk assessment tool shall be managed by physicians according to the Utah Medical Insurance Association guidelines. Additional reimbursement will be considered when criteria for high risk pregnancy care are met.

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T.N. # 88-5